



Jennifer Kent
Director

State of California—Health and Human Services Agency
Department of Health Care Services



EDMUND G. BROWN JR.
Governor

July 19, 2017

TO: ALL COUNTY WELFARE DIRECTORS Letter No. 17-25
ALL COUNTY ADMINISTRATIVE OFFICERS
ALL COUNTY MEDI-CAL PROGRAM SPECIALISTS/LIAISONS
ALL COUNTY HEALTH EXECUTIVES
ALL COUNTY MENTAL HEALTH DIRECTORS
CALIFORNIA DEPARTMENT OF AGING
CALIFORNIA DEPARTMENT OF DEVELOPMENTAL SERVICES
CALIFORNIA DEPARTMENT OF PUBLIC HEALTH
CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
ALL HCBS WAIVER ADMINISTRATORS/COORDINATORS

SUBJECT: Home and Community-Based Services and Spousal Impoverishment Provisions
(References: All County Welfare Directors Letters, Numbers 90-01, 90-03, 91-84; Medi-Cal Eligibility Procedures Manuel, Article 19-D)

The purpose of this letter is to clarify changes made by the Affordable Care Act (ACA) that broadened the definition of an “institutionalized spouse” [Section 1924(h) of the Social Security Act and by reference, therein, Section 1902(a)(10)(A)(ii)(VI)]. The new definition allows for a broader and more immediate application of the spousal impoverishment provisions for those receiving Home and Community-Based Services (HCBS). The spousal impoverishment provisions allow the community spouse to retain more income and resources upon submission of a Medi-Cal application for an institutionalized spouse or a spouse who requests HCBS.

This letter includes the following sections:

1. Description of Changes
2. Impacted Waivers and Programs
3. Process for Application of Spousal Impoverishment Provisions
 - Request for Services
 - Verification and Target Criteria
 - In-Home Supportive Services/Community First Choice Option (IHSS/CFCO)

- Coverage Groups
- Property and Income Eligibility or Share-of-Cost (SOC) - Examples 1 and 2
- 4. Ongoing Eligibility
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 - Eligibility Worker and Waiver Administrator/Care Coordinator Collaboration Required for Institutional Deeming
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- 7. Retroactive Implementation
 - CFCO
 - Denied Individuals
 - Individuals on Waiting Lists

1. Description of Changes

The changes are effective on January 1, 2014. The two major changes are described below.

- A) The spousal impoverishment provisions must be applied to individuals who will likely participate in the CFCO, part of the IHSS program, as verified by the Doctor's Verification form (see enclosure) or who pass the needs assessment for CFCO.
- B) The spousal impoverishment provisions must be applied as a Medi-Cal eligibility step upon request to participate in HCBS waivers or programs rather than once accepted into the applicable waiver or program. This letter instructs counties to immediately begin applying the spousal impoverishment provisions **at the time of application (application month), initial retroactive month, or in the month of initial request for HCBS (whichever comes first)**, upon:
1. receipt of the attached Doctor's Verification form indicating the person would likely require nursing facility level of care for 30 consecutive days in the absence of HCBS services, or
 2. receipt of a completed needs assessment if the individual went to a HCBS Care Coordinator before applying for Medi-Cal. An HCBS Care Coordinator is designated by the waiver or program administrator to assist potential HCBS participants with the enrollment process. The spousal impoverishment provisions shall continue to apply regardless of the individual's length of time

on a waiver waiting list. This means that even if the HCBS spouse is on the waiting list for months/years, the HCBS spouse will remain eligible in a separate budget unit from his/her spouse and the community spouse will continue to receive the benefit of the spousal impoverishment provisions.

The spousal impoverishment provisions described in this All County Welfare Directors Letter (ACWDL) apply to HCBS spouses who:

1. request HCBS and meet the target criteria of the waiver or programs based upon the [HCBS Program Eligibility Chart](#),
2. are married to a spouse who is not in a medical institution, nursing facility or otherwise an HCBS spouse¹, and
3. would likely require nursing facility level of care for at least 30 consecutive days in the absence of HCBS.

2. Impacted Programs and Waivers

The ACA expanded the federal definition of “institutionalized spouse” to permit the use of spousal impoverishment provisions for the following HCBS programs and waivers:

1. Section 1915(i) Developmental Disabilities State Plan Services
2. Assisted Living Waiver
3. Cal Medi-Connect Duals Demonstration Project for members eligible to receive Home and Community-Based Services and who would require institutionalization in the absence of HCBS – [Community Based Adult Services, Multipurpose Senior Services Program (MSSP)] and in lieu of institutional services provided under Care Plan Options)
4. California Community Transitions Home and Community-Based Services Money Follows the Person Grant
5. CBAS Medi-Cal 2020 Demonstration Waiver Benefit
6. Home and Community-Based Services for Persons with Developmental Disabilities (DD) Waiver
7. Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome Waiver
8. In-Home Operations Waiver
9. CFCO
10. MSSP Waiver
11. Nursing Facility/Acute Hospital – Transition and Diversion Waiver

¹ For the purposes of this ACWDL, an “HCBS spouse” is an individual for whom spousal impoverishment provisions are applied as described in this ACWDL. The HCBS spouse is an institutionalized spouse pursuant to the federal definition [Social Security Act, Section 1924(h)].

12. Pediatric Palliative Care Waiver
13. Program of All-inclusive Care for the Elderly
14. San Francisco Community Living Support Benefit Waiver
15. Self-Directed Program for Persons with DD Waiver (program in the approval process)
16. Senior Care Action Network Fully Integrated Dual Eligible Special Needs Plan

More information about HCBS may be found at the following link.

<http://www.dhcs.ca.gov/services/ltc/Pages/default.aspx>

3. Process for Application of Spousal Impoverishment Provisions

Request for Services - The person requesting HCBS services may initiate this process either by applying for Medi-Cal first, or by first contacting a waiver administrator or a care-coordinating agency that works with the waiver administrator to request participation in the waiver. The waiver administrator or care coordinator would then follow current processes to refer the individual to the County for a Medi-Cal eligibility determination.

Verification and Target Criteria - The County Eligibility Worker (CEW) provides the enclosed Doctor's Verification form unless the applicant has already completed a needs assessment for the waiver or program through the waiver administrator/care coordinator. The CEW must require the applicant, his/her spouse or authorized representative to sign the attached authorization for the doctor to release his/her information to the CEW, and provide the name and address of the individual's doctor. The individual's doctor must sign and return the form as evidence that the individual would likely require nursing facility level of care for at least 30 consecutive days without HCBS. Counties must provide translation services in accordance with state and federal law.

The doctor must be allowed at least 10 business days to submit the form to the county in a postage paid return envelope provided by the county or, if available in the county, by secured email or fax. If the doctor's office does not return the form, the CEW must contact the doctor's office to confirm that they received the form and to provide another copy of the form if it was not. If the client indicates that he/she wants to bring the form to the doctor's office, they may do so, but advise the client that the doctor must submit the completed form to the county. If the client returns the form, the CEW will need to contact the doctor's office to confirm the validity of the signature and information. If the CEW still does not receive the form, then the CEW must advise the applicant/beneficiary or authorized representative of the situation, and that the client will still receive a needs

assessment for CFCO or the waiver and, if approved, that the spousal impoverishment provisions will apply. When all efforts to obtain the Doctor's Verification form from the doctor's office have failed, if the CEW can establish eligibility for Medi-Cal without the benefit of spousal impoverishment provisions, the CEW must grant eligibility. The CEW must then revise the case if the needs assessment is approved, back to the month of application; or in the case of a beneficiary, the CEW should revise the case back to the date of initial request for HCBS. The CEWs will need to inform the waiver administrators or care coordinators regarding the outcomes of the Medi-Cal eligibility determinations, and the waiver administrators or care coordinators will need to inform the CEWs regarding participant approvals or disapprovals.

The waiver administrator/care coordinator needs to work with the CEW to establish, redetermine and discontinue cases as appropriate. Lines of communication between CEWs and HCBS waivers and programs already exist in most Counties. Contact information for each waiver administrator is included on the [County Operations Support](#) section of the Department of Health Care Services (DHCS) website and in the HCBS Program Eligibility Chart enclosure with this ACWDL.

The waiver administrator are able to provide the name and contact information for their contracted care coordinators. Each party should have an authorization to release information signed by the applicant, beneficiary, or their authorized representative. The CEW should document telephone contacts with and confirmations by, the waiver administrator/care coordinator in the case record.

In the past, the waiver administrator/care coordinator had to inform the CEW of approval pending Medi-Cal eligibility or confirm HCBS participation before the CEW could apply spousal impoverishment provisions. Now, if the client meets the target criteria for the waiver or program, and is otherwise eligible, the CEW will apply the spousal impoverishment provisions when the CEW receives the Doctor's Verification form unless he/she has already passed the waiver needs assessment. The **minimum** target criteria of each HCBS waiver or program **is nursing facility level of care for at least 30 consecutive days in the absence of HCBS and additional target criterion**, as described by the enclosed chart. If the waiver administrator/care coordinator has not completed the needs assessment, as described above, a completed Doctor's Verification form will establish that the individual meets the nursing facility level of care target criteria for the waiver or program. The CEW shall then apply the spousal impoverishment provisions in accordance with ACWDLs 90-01, 90-03, and 91-84, beginning with the first month in which the person requests both Medi-Cal and HCBS. That first month could be the initial retroactive month, the month of application, or, in the case of someone who is already a Medi-Cal beneficiary, the first month of the request for HCBS services.

IHSS/CFCO - Counties shall establish their own lines of communication between staff establishing eligibility for IHSS and Medi-Cal for the purposes of identifying CFCO individuals. The communication must occur as soon as the HCBS spouse requests IHSS. The CEW must still refer the individual to IHSS for a needs assessment, however, the CEW shall establish eligibility under the spousal impoverishment provisions as soon as either; the needs assessment indicates that the individual meets the clinical criteria for CFCO participation, **or** the doctor returns the completed Doctor's Verification form. Later on, if IHSS identifies the individual as not meeting the clinical standard for being a CFCO recipient, the CEW must redetermine the individual's eligibility without the spousal impoverishment provisions and adjust the SOC or discontinue for excess property, as necessary.

Coverage Groups - When determining the eligibility of an HCBS spouse, the CEW determines eligibility for the various Medi-Cal coverage groups in accordance with the Medi-Cal hierarchy. First, HCBS is available to individuals who are eligible for Medi-Cal under the Modified Adjusted Gross Income (MAGI) rules. The spousal impoverishment provisions are not relevant to the MAGI coverage groups. When determining eligibility for HCBS under the Non-MAGI programs, conduct the determination in the same manner as set forth in ACWDL 90-01 and 91-84, with the modifications described in this ACWDL. The Non-MAGI hierarchy for eligibility screening is Aged, Blind, and Disabled Federal Poverty Level (ABD FPL) group, the 250 percent Working Disabled program, and finally Medically Needy (MN) program with or without a SOC.

Property and Income Eligibility or SOC - Property eligibility is established allowing for the Community Spouse Resource Allowance (CSRA) and the property reserve for the HCBS spouse in a separate Medi-Cal Family Budget Unit pursuant to ACWDL 90-01 and 91-84 beginning in the initial month for which Medi-Cal HCBS is being requested. Then, the spousal income allocation to the community spouse is determined in the same manner as set forth in ACWDL 90-03 and ACWDL 91-84. If the community spouse's gross income minus health insurance premiums is greater than the Minimum Monthly Maintenance Needs Allowance (MMMNA), there is no spousal income allocation from the HCBS to the community spouse. Apply community eligibility rules with a budget unit for one person living in the community to the income of the HCBS spouse remaining after the spousal income allocation, if any. The personal needs allowance of \$35 does **not** apply to individuals in HCBS who are living in the community. If the HCBS spouse is eligible for one of the Non-MAGI no-SOC coverage groups (e.g. the ABD FPL group), eligibility is completed. No further actions are necessary unless:

- an annual redetermination is due – which will follow the same process for income, as depicted in ACWDL 90-03,

- the individual is found not to meet the clinical standard/needs assessment,
- there is a change in circumstances, or
- the HCBS spouse becomes ineligible.

Please Note: With the spousal impoverishment rules in the Medi-Cal eligibility determination, there is no need for a separate institutional deeming income calculation under the waiver if the HCBS spouse is eligible without a SOC.

Examples 1 and 2

Example 1: Mr. A., age 72, applies for Medi-Cal on May 3, 2015. He has a spouse, Mrs. A., who is not requesting Medi-Cal. They live together at home in the community. Mr. A. is not eligible for any of the MAGI programs or any other mandatory categorical coverage group, but he is requesting to participate in the MSSP Waiver and the spousal impoverishment provisions apply.

Mr. and Mrs. A. have combined net nonexempt property of \$98,000. That amount is within the property limit for one plus the 2016 CSRA of \$119,220, so they are property eligible. Mr. A. will have to remove his name from at least \$96,000 (\$98,000 - \$2,000 property limit for one) of this nonexempt property before the end of the CSRA transfer period (the end of the month that includes the 90th day from the date that the Notice of Action (NOA) is sent to Mr. A., stating that he is eligible).

Mr. A. is determined eligible for the Aged and Disabled FPL (A&D FPL) program and his income calculation is as follows:

Mr. A.'s Income	Mrs. A.'s Income
\$2,000.00 Social Security	\$900.00 Social Security
- \$20.00 Any Income Deduction	- \$120.90 Medicare Premium
- \$120.90 Medicare Premium	\$779.10 Gross Income Minus Other Health Insurance
- \$230.00 Standard Deduction	\$3023.00 MMMNA (2017)
\$1629.10 Net Nonexempt Income	- \$779.10 Gross Income Minus Other Health Insurance
\$1629.00 Rounded	\$2243.90 Potential Spouse Income Allocation (\$2244 Rounded)
- \$981.00 A&D FPL Income Limit (1)	
\$648.00 In this case, only \$648.00 is available to be allocated from Mr. A.	

Example 2: Mr. B., disabled and age 60, has Medicare and applies for HCBS. Mr. B. has a spouse, Mrs. B., who is not requesting Medi-Cal and has employer sponsored full coverage health insurance. Mr. B. is not working and receives disability retirement benefits from his job. Mr. B. is not MAGI eligible. The couple’s combined net nonexempt property (\$60,000) is within the CSRA plus \$2,000 limit so Mr. B. will need to remove his name from \$58,000 of the \$60,000 net nonexempt property by the end of the CSRA transfer period.

Mr. B. has too much income to qualify for the A&D FPL program, so his eligibility must be determined under the MN program.

Mr. B.’s Income		Mrs. B.’s Income	
\$2200.00	Disability Retirement Benefits	\$2522.00	Gross Earned Income
- \$20.00	Any Income Deduction	- \$300.00	Health Insurance Premiums
- \$120.90	Medicare Premiums	\$2222.00	Gross Income Minus Other Health Insurance
\$2059.00	Net Nonexempt Income (rounded)	\$3023.00	MMMNA (2017)
- \$759.00	Spousal Income Allocation	- \$2222.00	Gross Income Minus Other Health Insurance
- \$600.00	MN Level for (one) 1*	\$759.00	Potential Spousal Income Allocation
\$700.00	SOC		

*If the waiver allows for special income deductions not already allowed under the MN calculation above, deduct them just before the final determination of the SOC amount.

4. Ongoing Eligibility

If an approved request for HCBS results in the individual’s placement on a waiting list, then the spousal impoverishment provisions shall continue to apply. The HCBS care coordinator or administrator will provide verification of the level of care and eligibility for HCBS to the CEW during the clinical/needs assessment for HCBS participation. Once the individual becomes an HCBS spouse, he/she begins a continuous period of HCBS (also known as a continuous period of institutionalization). Once the continuous period of HCBS or institutionalization begins, the continuous period shall continue in tandem with and in the same manner as the continuous period of institutionalization in accordance with Section 50033.5 of ACWDL 90-01. This reduces difficulties for individuals who frequently transition on and off HCBS, or who go in and out of medical

institutions or nursing facilities. The HCBS spouse, community spouse, beneficiary representative, administrator, or care coordinator need only confirm continued HCBS participation at annual renewal, just as an institutionalized spouse would confirm continued institutionalization on their renewal forms, as long as the period of HCBS participation or institutionalization continues. The continuous period ends when the HCBS spouse or institutionalized spouse does not receive HCBS or inpatient care in a medical institution or nursing facility for a full calendar month. There is no need for additional verification of level of care, or of the CSRA after the first month of eligibility under the spousal impoverishment provisions, in accordance with ACWDL 90-01. At the end of the CSRA transfer period, CEWs should verify that the HCBS spouse has no more than \$2,000 of nonexempt property remaining in his or her name.

Once determined eligible using the spousal impoverishment provisions, the HCBS spouse remains eligible, aside from a change in circumstance, until the request for HCBS is denied because the individual did not meet the clinical standard for the waiver, or the individual is not identified as a CFCO recipient, and a 10-day notice of adverse action can be provided. Changes in circumstance would include such things as, death, moved out of state, dissolution of the marriage, or no longer in need of the services for a full calendar month ending the continuous period of institutionalization. This will require communication between the IHSS worker or the waiver administrator/care coordinator and the eligibility worker.

5. Institutional Deeming Under The Waivers

When the MN determination results in a SOC, even with the spousal income allocation, the CEW shall be consider the HCBS spouse under the institutional deeming provisions of the waiver. However, if the waiver allows an income allocation to the community spouse, then that would no longer apply under the institutional deeming rules because the community spouse is now receiving the benefit of the spousal income allocation up to the MMMNA initially in the eligibility determination.

Additional Waiver Property Exemptions or Income Deductions Apply Only At Waiver Participant's Start Date

Currently, the only property exemptions permitted beyond the spousal impoverishment provisions include the second modified vehicle available in some waivers and the Assisted Living Waiver's board and care income deduction. After the deduction of the CSRA from the spouses' combined community and separate property, any special waiver exemptions apply. After the deduction of the spousal income allocation, any special waiver deductions apply to the HCBS spouse's net nonexempt income that remains before the SOC result is determined. The CEW should discuss these special

waiver exemptions or deductions, if any, with the waiver administrator/care coordinator and apply them in the month of the waiver start date. If the individual does not have a start date to participate in the waiver and it is possible to establish eligibility under the spousal impoverishment provisions without the special waiver exemptions or deductions, CEWs should do so. When the start date is available, the CEW must redetermine eligibility with the special waiver exemptions and deductions to be effective the month of that start date.

Eligibility Worker and Waiver Administrator/Care Coordinator Collaboration Required for Institutional Deeming

The eligibility worker and waiver administrator/care coordinator, must work together to coordinate this dual process to have participation in the waiver and institutionally deemed Medi-Cal eligibility, with or without a SOC begin concurrently for the same month.

When the waiver administrator/care coordinator refers the HCBS spouse to the County for a Medi-Cal eligibility determination:

1. If the waiver administrator/care coordinator completed the needs assessment with a start date pending Medi-Cal eligibility, the eligibility worker can then complete the eligibility determination following the processes indicated above.
2. If the waiver administrator/care coordinator has not yet completed the needs assessment, the eligibility worker shall stop before completely granting eligibility. The eligibility worker must inform the waiver administrator/care coordinator about the individual's potential eligibility status. Meanwhile, the waiver administrator/care coordinator completes the needs assessment and informs the eligibility worker whether the individual has passed the clinical standard or needs assessment and is ready to participate in the waiver. If both are approvable, the eligibility worker shall establish the eligibility as institutionally deemed effective the first of the month of participation.

6. What Happens If the Community Spouse Applies, Becomes Institutionalized or Requests HCBS

If the community spouse requests Medi-Cal, then the community spouse will need to spend down his/her property to the property limit for one. A spousal income allocation would still be permitted and the couple is permitted to adjust the amount in whatever manner they determine is best in order to preserve the eligibility for each spouse (this

would also be applicable in the case of a spouse who is a recipient of Supplemental Security Income).

Example 3

Example 3: If the community spouse applied and had net nonexempt income that was \$200.00 under the A&D FPL limit and had previously been receiving a higher spousal income allocation from the institutionalized spouse, the couple may decide that it is important to them to ensure the eligibility of the community spouse. They may decide to reduce or stop the spousal income allocation, even though this would increase the net nonexempt income of the institutionalized spouse by the same amount and potentially increase his/her SOC.

Mr. C.'s Income		Mrs. C.'s Income	
\$2000.00	Social Security	\$900.00	Social Security
- \$20.00	Any Income Deduction	- \$120.90	Medicare Premium
- \$120.90	Medicare Premium	\$779.10	Gross Income Minus Other Health Insurance
- \$230.00	Standard Deduction	\$3023.00	MMMNA (2017)
- \$201.90	Spousal Income Allocation	\$779.10	Gross Income Minus Other Health Insurance
\$1427.00	Net Nonexempt Income	+ \$201.90	Mrs. C wants Medi-Cal under the A&D FPL program; therefore, only \$201.90 may be allocated
- \$600.00	MN Maintenance Need Allowance	\$981.00	Net Nonexempt Income
\$827.00	SOC	- \$981.00	A&D FPL Income Limit
		\$0	Excess Income

If the community spouse becomes institutionalized, even though he/she may not request Medi-Cal, he/she no longer meets the definition of a community spouse. Because the federal law has changed the definition of an institutionalized spouse to include an HCBS spouse, in this situation, there would be no community spouse. If both spouses request HCBS services, then the spousal impoverishment provisions would not apply. This couple would have their eligibility determined as living together in the community.

Please Note: This ACWDL does not change or broaden the definition of an institutionalized individual, as contained in ACWDL 90-01. An institutionalized individual is an actual "resident in a nursing facility or medical institution and receiving nursing

facility level of care” (see ACWDL 90-01, Section 50046.4 of that letter). In this ACWDL, HCBS spouses are included in the definition of institutionalized spouse only for receiving the benefit of the spousal impoverishment provisions.

7. Retroactive Implementation:

CFCO – In the past, the terms of the HCBS waivers or programs allowed spousal impoverishment provisions. Since CFCO did not have spousal impoverishment provisions applied at its implementation, retroactive eligibility determinations are required. CEWs shall utilize the spousal impoverishment provisions for HCBS spouses who requested IHSS and:

- Became CFCO participants on or after January 1, 2014, or
- Provide the Doctor’s Verification identifying them as likely to require nursing facility level of care for at least 30 consecutive days in the absence of HCBS beginning with a date that is on or after January 1, 2014.

For retroactive determinations, CEWs need to review eligibility of HCBS spouses who are, or were in CFCO aid code 2K with a SOC on or after January 1, 2014. A doctor’s letter is not required. The spousal impoverishment provisions shall apply back to the month in which the HCBS spouse became a 2K CFCO participant. Counties must immediately begin working with their IHSS staff and/or their Statewide Automated Welfare Systems to identify HCBS spouses in aid code 2K anytime on or after January 1, 2014.

Denied or Discontinued Individuals - CEWs must also complete retroactive eligibility determinations for married individuals who requested HCBS but were denied Medi-Cal or discontinued in accordance with the process above. This may have occurred upon discharge from a medical institution or nursing facility due to excess property at the time the individual requested HCBS participation. In these cases, the form from the doctor is required to establish when the individual required nursing facility level of care for 30 consecutive days at the time of the individual’s request for HCBS back to January 1, 2014.

The CEWs shall rescind any denials or discontinuances of eligibility due to excess property and retroactively adjust any SOCs as far back as January 1, 2014 whenever an the individual would have been an eligible HCBS spouse and:

- CEWs become aware of a cases, described above,
- at annual redetermination,
- when a fair hearing is requested, or

- when an individual requests a retroactive redetermination.

CEWs shall issue new NOAs and work with clients to obtain provider reimbursements by issuing the “Share-of-Cost Medi-Cal Provider Letter” (MC 1054) and “Eligibility Letter of Authorization” (MC 180) (otherwise known as the “More Than One-Year Letter”) as appropriate. CEWs shall also communicate and coordinate with County IHSS staff to procure reimbursement of SOCs paid for in-home care for the HCBS spouse. The County shall utilize Conlan v. Bontá and Conlan v. Shewry processes for both Medi-Cal and IHSS for reimbursements as necessary in accordance with ACWDL 07-01.

Individuals On Waiting Lists Prior to this ACWDL – DHCS in partnership with the County Welfare Directors Association, counties, and stakeholders will establish a plan to outreach and process retro eligibility for married individuals who were placed on a waiver waiting list after January 1, 2014 and prior to the release of this ACWDL. DHCS will issue further guidance on the processing of these cases. If a county becomes aware of a case, then the county must ensure retroactive eligibility determinations are completed for the HCBS spouses in accordance with this ACWDL.

The Statewide Automated Welfare Systems shall make all changes necessary to implement these policy changes in their next available release.
If you have questions about this letter, please contact one of the following staff by phone or email:

Name	Phone Number	Email Address
Sharyl Shanen-Raya	(916) 552-9449	Sharyl.Shanen-Raya@dhcs.ca.gov
Leanna Pierson	(916) 327-0408	Leanna.Pierson@dhcs.ca.gov
Tammy Kaylor	(916) 327-0406	Tammy.Kaylor@dhcs.ca.gov

Original Signed By Robert Sugawara for

Sandra Williams, Chief
Medi-Cal Eligibility Division

Enclosures

(COUNTY LETTERHEAD)

(DATE)

PATIENT'S INFORMATION (County Completes This Section)	
PATIENT NAME:	PATIENT DATE OF BIRTH:
CLIENT INDEX NUMBER (CIN):	

Dear Dr. _____

Please complete and return the statement below by _____ regarding your patient listed above so that we can determine his\her eligibility for Medi-Cal. Please use the postage paid pre-addressed envelope. You may also return it by fax or email as indicated below. Your patient has given authorization to release this information to us. Please see attached patient authorization.

County Worker Signature: _____ Date: _____

County Worker Printed Name: _____

Phone Number: _____ Fax Number: _____

County Worker Email: _____

Doctor's Verification for Home and Community Based Services Under Spousal Impoverishment Provisions

DOCTOR'S INFORMATION	
DOCTOR'S PRINTED NAME:	DATE:
TELEPHONE:	EMAIL:

Based on my examination, my patient, _____, will likely require nursing facility level of care for at least 30 consecutive days unless he/she receives in-home care and support services that will permit him/her to reside safely at home. My patient first began needing these services at a nursing facility level of care on _____, and has continued to need these services since that date.

I declare under penalty of perjury under the laws of the United States of America and the State of California that the information contained in this Doctor's Verification is true and correct.

DOCTOR'S SIGNATURE:

(COUNTY LETTERHEAD)

(DATE)

Patient Authorization

I, _____

authorize doctor _____

to release the medical information on this form to _____ County for the purpose of establishing my eligibility for Medi-Cal.

- I authorize the use or disclosure of my individually identifiable health information as described above for the purpose listed.
- I have the right to withdraw permission for the release of my information. If I sign this authorization to use or disclose information, I can revoke that authorization at any time. The revocation must be made in writing and will not affect information that has already been used or disclosed.
- I have the right to receive a copy of this authorization.
- I am signing this authorization voluntarily and treatment, payment, or my eligibility for benefits under this program may not be possible if I do not sign this authorization.
- I further understand that a person to whom records and information are disclosed pursuant to this authorization may not further use or disclose the medical information unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

SIGNED: _____ DATE: _____

If not signed by the patient who is the subject of this disclosure, specify basis for authority to sign:

- Parent of Minor Guardian Spouse Authorized Representative

Explain relationship to the patient and why the patient is unable to sign:

WITNESS: I know the person signing this form or am satisfied of this person’s identity: (Required for “X”, illegible, or foreign character signatures)

Witness signature: _____ Date: _____

Street Address: _____ City/Zip Code: _____

This general and special authorization to disclose information has been developed to comply with the provisions regarding disclosure of medical and other information under: The Health Insurance Portability and Accountability Act, Section 262(a), 42 U.S.C, Section 1320d-1320d-8 (45 CFR Part 164); 42 U.S.C., Section 290dd-2 (42 CFR Part 2); 38 U.S.C., Section 7332; 20 U.S.C., Section 1232g (34 CFR Parts 99 and 300); and state law, including Civil Code, Section 56.10(b), Welfare and Institutions Code, Section 10850 and 14100.2 and Civil Code, Sections 1798-1798.78.